

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State WASHINGTONMETHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES FOR INPATIENT
HOSPITAL SERVICES (cont.)

D. DRG COST-BASED RATE METHOD (cont.)

1. Base Period Cost and Claims Data (cont.)

Nine categories are used to assign hospitals' accommodation costs and days of care, and 29 categories are used to assign ancillary costs and charges. Medicaid paid claims data for each hospital's FY 1998 period are extracted from the state's Medicaid Management Information System (MMIS).

Department of Health Composite Hospital Abstract Reporting System (CHARS) claims representative of services covered and provided by Healthy Options managed care plans are also extracted. Line item charges from claims are assigned to the appropriate 9 accommodation and 29 ancillary cost center categories and used to apportion Medicaid costs. These data are also used to compute hospitals' FY 1998 case-mix index.

2. Peer Groups & Caps

MAA's peer grouping has six classifications: Peer group A, which are non-CAH, rural hospitals which are not in peer group E and for Medicaid claims are paid under an RCC methodology; peer group B, which are non-CAH urban hospitals without medical education programs which are not in peer group E; peer group C, which are urban hospitals with medical education programs which are not in peer group E; peer group D, which are specialty hospitals which are not in peer group E; peer group E, which are public hospitals located in the State of Washington that are owned by public hospital districts and are not department approved and DOH certified as CAH, the Harborview Medical Center, and the University of Washington Medical Center; and peer group F, which are hospitals located in the State of Washington that are department approved and DOH certified as CAH.

For the DRG payment method, indirect medical education costs are removed from operating and capital costs, and direct medical education costs are added.

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2. Peer Groups & Caps (cont.)

Peer group caps for peer groups B and C are established at the 70th percentile of all hospitals within the same peer group for aggregate operating, capital, and direct medical education costs. In computing hospitals' rates, hospitals whose costs exceed the 70th percentile of the peer group are reset at the 70th percentile cap. The hospitals in peer group D are exempted from the caps because they are specialty hospitals without a common peer group on which to base comparisons. The hospitals in peer group E are exempted from the peer group caps because they are paid "full cost" of services as determined through the Medicare Cost Report using the Medicaid RCC rates to determine cost. The hospitals in peer group F are also exempted from the peer group caps.

Changes in peer group status as a result of MAA approval or recommendation are recognized. However, in cases where post-rate calculation corrections or changes in individual hospital's base year cost or peer group assignment result in a change in the peer group cost at the 70th percentile, and thus have an impact on the peer-group cap, the cap is updated only if it results in a 5.0 percent or greater change in total Medicaid payment levels.

3. Conversion Factor Adjustments

Indirect medical education costs are added back into costs before application of any inflation adjustment. A 0.008219 percent per day inflation adjustment (3.0 percent divided by 365 days) is used for hospitals that have their fiscal year ending before December 31, 1998. A 9.1086 percent inflation adjustment is used for the period from January 1, 1999 to October 31, 2001.

Annually all cost-based conversion factors are adjusted by a predetermined vendor rate adjustment.

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4. Medicaid Cost Proxies

In some instances, hospitals had Medicaid charges (claims) for certain accommodation or ancillary cost centers that are not separately reported on their Medicare cost report. To ensure recognition of Medicaid related costs, proxies are established to estimate these costs. Per diem proxies are developed for accommodation cost centers; RCC proxies for ancillary cost centers.

5. Case-Mix Index

Under DRG payment systems, hospital costs must be case-mix adjusted to arrive at a measure of relative average cost for treating all Medicaid cases. A case-mix index for each hospital is calculated based on the Medicaid cases for each hospital during its FY 1998 cost report period.

6. Indirect Medical Education Costs

An indirect medical education cost is established for operating and capital components in order to remove indirect medical education related costs from the peer group caps.

To establish this factor, a ratio based on the number of interns and residents in approved teaching programs to the number of hospital beds is multiplied by the Medicare's indirect cost factor of 0.579. The resulting ratio is multiplied by a hospital's operating and capital components to arrive at indirect medical education costs for each component.

The indirect medical cost is trended forward using the same inflation factors as apply to the operating and capital components and added on as a separate element of the rate as described in paragraph 7.

7. Rate Calculation Methodology

Step 1: For each hospital, the base period cost data are used to calculate total costs of the operating, capital, and direct medical education cost components in each of the nine accommodation categories. These costs are divided by total hospital days per category to arrive at a per day accommodation cost.

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7. Rate Calculation Methodology (cont.)

The accommodation costs per day are multiplied by the total Medicaid days to arrive at total Medicaid accommodation costs per category for the three components.

Step 2: The base period cost data are also used to calculate total operating, capital and direct medical education costs in each of the 29 ancillary categories. These costs are divided by total charges per category to arrive at a cost-to-charge ratio per ancillary category.

These ratios are multiplied by MMIS Medicaid charges per category to arrive at total Medicaid ancillary costs per category for the three components.

Step 3: The Medicaid accommodation and ancillary costs are combined to derive the operating, capital and direct medical education's components. These components are then divided by the number of Medicaid cases to arrive at an average cost per admission.

Step 4: The three components' average cost per admission are next adjusted to a common fiscal year end (December 31, 1998) using the appropriate DRI-HCFA Type Hospital Market Basket update and then standardized by dividing the average cost by the hospital's case-mix index.

Step 5: The indirect medical education portion of operating and capital is removed for hospitals with medical education programs. Outlier costs were also removed. For hospitals in Peer Group B and C, the three components aggregate cost is set at the lesser of: hospital specific aggregate cost or the peer group cap aggregate cost.

Step 6: The resulting respective costs with the indirect medical education costs and an outlier factor added back in are next multiplied by the DRI-HCFA Type Hospital Market Basket update for the period January 1, 1999 through October 31, 2001. The outlier set-aside factor is then subtracted to arrive at the hospital's January 1, 2001 cost-based rate. This cost-based rate is multiplied by the applicable DRG weight to determine the DRG payment for each admission.

Those in-state and border area hospitals with insufficient data will have rates based on the peer group average final conversion factor for their hospital peer group less the outlier set aside factor.

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8. Border Area Hospitals Rate Methodology

Border area hospitals include facilities located in areas defined by state law as: Oregon - Astoria, Hermiston, Hood River, Milton-Freewater, Portland, Rainier, and The Dalles; Idaho - Coeur d'Alene, Lewiston, Moscow, Priest River and Sandpoint.

These hospitals' cost-based rates are based on their FY 1998 Cost Reports and FY 1998 claims, if available.

Those border area hospitals with insufficient data will have rates based on the peer group average final conversion factor for their hospital peer group less the outlier set aside factor.

9. New Hospitals Rate Methodology

New hospitals are those entities that have not provided services prior to January 1, 2001. A change in ownership does not constitute the creation of a new hospital. New hospitals' cost-based rates are based on the peer group average final conversion factor for their hospital peer group, less the outlier set aside factor.

10. Change in ownership

When there is a change in ownership and/or the issuance of a new federal identification, the new provider's cost-based rate is the same rate as the prior owner's.

Depreciation and acquisition costs are recaptured as required by Section 1861 (V) (1) (0) of the Social Security Act. Mergers of corporations into one entity with subproviders receive a blended rate based on the old entities rates. The blended rate is weighted by admission for the new entity.

E. RCC RATE METHOD

The RCC payment method is used to reimburse Peer Group A hospitals for their costs and other hospitals for certain DRG exempt services as described in Section C.8. This method is not used for hospitals reimbursed using the "full cost" CPE method except that the Medicaid RCC rates are used to determine "full cost" for those hospitals.

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E. RCC RATE METHOD (cont)

The RCC ratio for out-of-state hospitals is the average of RCC ratios for in-state hospitals. The RCC ratio for in-state and border area hospitals which the State determines have insufficient data or Medicaid claims to accurately calculated an RCC ratio, is also the average of RCC ratios for in-state hospitals. Hospital's RCC ratios are updated annually with the submittal of new CMS 2552 Medicare cost report data. Increases in operating expenses or total rate-setting revenue attributable to a change in ownership are excluded prior to computing the ratio.

F. "FULL COST" PUBLIC HOSPITAL CERTIFIED PUBLIC EXPENDITURE (CPE)
PAYMENT METHODOLOGY (effective July 1, 2005)

The public hospitals located in the State of Washington that are owned by public hospital districts and are not department approved and DOH certified as CAH, the Harborview Medical Center, and the University of Washington Medical Center, will be reimbursed using the "full cost" payment method using their respective Medicaid RCC rate to determine cost for covered medically necessary services. The payment method incorporates the use of certified public expenditures (CPEs) at each hospital as the basis for claiming federal Medicaid funding for the cost of medically necessary patient care. Recipient responsibility (spend-down) and third-party liability as identified on the billing invoice or by DSHS is deducted from the allowed amount (basic payment) to determine the actual payment for that admission. The costs as determined above will be certified as actual expenditures by the hospital and the DSHS claim will be the allowed federal match on the amount of the related certified public expenditures. DSHS will verify that the expenditures certified were actually incurred.

G. DISPROPORTIONATE SHARE PAYMENTS

As required by Section 1902(a)(13)(A) and Section 1923(a)(1) of the Social Security Act, the Medicaid reimbursement system takes into account the situation of hospitals which serve a disproportionate number of low-income patients with special needs by making a payment adjustment for eligible hospitals. To be eligible for any disproportionate share program, a hospital must meet the Medicaid one-percent utilization to qualify. A hospital will receive any one or all of the following disproportionate share hospital (DSH) payment adjustments if the hospital meets the eligibility requirements for that respective DSH payment component.

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G. DSH PAYMENTS (cont.)

All the DSH payments will not exceed the State's DSH allotment. To accomplish this goal, it is understood in this State Plan that the State intends to adjust their DSH payments to ensure that the costs incurred by Medicaid and uninsured patients are covered to the maximum extent permitted by the State's DSH allotment.

In accordance with the Omnibus Budget Reconciliation Act of 1993, the amounts paid under DSH programs to public hospitals will not exceed 100 percent of cost, except as allowed by subsequent federal guidelines.

Cost is established through prospective payment methods and is defined as the cost of services to Medicaid patients, less the amount paid by the State under the non-DSH payment provisions of the State Plan, plus the cost of services to indigent and uninsured patients, less any cash payments made by them.

DSHS will not exceed the DSH statewide allotment nor allow a hospital to exceed the DSH limit. The following clarification of the process explains precautionary procedures.

All the DSHS DSH programs' payments are prospective payments, and these programs are: LIDSH, MIDSH, GAUDSH, SRHAPDSH, SRHIAAPDSH, NRHIAAPDSH, THAPDSH (ends June 30, 2005), STHFPDSH (ends June 30, 2005), CTHFPDSH (ends June 30, 2005) and PHDDSH.

DSH programs for which payments are fixed represent 97 percent of DSHS' disproportionate share payments to hospitals. The other two DSH programs, MIDSH and GAUDSH, are paid on a by-claims basis. To adjust for these unknowns in the MIDSH and GAUDSH, MAA uses claims data and estimates what expected expenditures would be paid during the current state fiscal year. This estimate then becomes a part of the hospital's cost limit.

The Medical Assistance Administration (MAA) will monitor payments monthly. Each month, MAA will receive an MI Summary Report and GAU Summary Report from the Medicaid Management Information System (MMIS) identifying expenditures paid to each hospital under the MIDSH and GAUDSH programs.

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G. DSH PAYMENTS (cont.)

Each month MAA will also receive the DSHS Allotment/Expenditure Transaction Register identifying the remaining DSH program expenditures. The figures in these reports will be accumulated monthly to determine that hospitals have not exceeded the DSH limit.

If a hospital reaches its DSH limit, payments will be stopped. The Department of Social and Health Services (DSHS) will determine the extent to which and how each DSH program is funded. Any specific guidance that may be provided by the State legislature will be followed by DSHS.

If a hospital exceeds its DSH limit, DSHS will recoup the DSH payments in the following program order: PHDDSH, THAPDSH (ends June 30, 2005), CTHFPDSH (ends June 30, 2005), STHFPDSH (ends June 30, 2005), SRHAPDSH, NRHIAAPDSH, SRHIAAPDSH, GAUDSH, and LIDSH. For example, if a hospital were receiving payments from all DSH programs, the overpayment adjustment would be made in PHDDSH to the fullest extent possible before adjusting THAPDSH payments. If the DSH state-wide allotment is exceeded, DSHS will similarly make appropriate adjustments in the program order shown above.

1. Low-Income Disproportionate Share Hospital (LIDSH) Payment

Hospitals shall be deemed eligible for a LIDSH payment adjustment if:

- a. The hospital's Medicaid inpatient utilization rate (as defined in Section 1923(b)(2)) is at least one standard deviation above the mean Medicaid inpatient utilization rate of hospitals receiving Medicaid payments in the State; or,
- b. The hospital's low-income utilization rate (as defined in Section 1923 (b) (3)) exceeds 25 percent.
- c. The hospital qualifies under Section 1923 (d) of the Social Security Act.

Hospitals deemed eligible under the above criteria shall receive disproportionate share payment amounts that in total will equal the funding set by the State's appropriations act for LIDSH. The process of apportioning payments to individual hospitals is as follows:

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G. DSH PAYMENTS (cont.)

1. LIDSH Payments (cont.)

A single base payment is selected that distributes the total LIDSH appropriation. For each hospital, the base payment is multiplied by the hospital's low income utilization factor standardized to one, by the hospital's most recent Fiscal Year case mix index by the hospital's subsequent year's estimated admissions of Title XIX eligibles. Results for all hospitals are summed and compared to the appropriated amount.

If the sum differs from the appropriated amount, a new base payment figure is selected. The selection of base payment figures continues until the sum of the calculated payment equals the appropriated amount. The appropriation amount may vary from year to year. Each hospital's disproportionate share payment is made periodically.

2. Medically Indigent Disproportionate Share Hospital (MIDSH) Payment

Effective July 1, 1994, hospitals shall be deemed eligible for a MIDSH payment if:

- a. The hospital is an in-state or border area hospital; and,
- b. The hospital provides services to low-income, Medically Indigent (MI) patients. MI persons are low-income individuals who are not eligible for any health care coverage and who are encountering an emergency medical condition; and,
- c. The hospital has a low-income utilization rate of one percent or more; and,
- d. The hospital qualifies under Section 1923 (d) of the Social Security Act.

Effective through June 30, 2005, hospitals shall be deemed eligible for a MIDSH payment of claims for dates of service prior to July 1, 2003 if the payment is for services to MI patients provided prior to July 1, 2003.

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G. DSH PAYMENTS (cont.)

2. MIDSH Payments (cont.)

Hospitals shall be deemed eligible for a MIDSH payment of claims for services provided on or after July 1, 2003, only for Psychiatric Indigent Inpatient (PII) services and when requirements a. through d., above, are met. PII services are for low-income individuals who are not eligible for any health care coverage and require psychiatric medical care.

Hospitals qualifying for MIDSH payments will receive a periodic per claim payment. The payment is determined for each hospital by reducing the regular Medicaid payment by a ratable reduction factor and equivalency factor adjustment. The ratable reduction is inversely proportional to the percent of a hospital's gross revenue for Medicare, Medicaid, Labor and Industries, and charity. The equivalency factor reduction is a budget neutral adjustment applied to all hospitals. The equivalency factor ensures that MIDSH payments will equal the State's estimated MIDSH appropriation level.

Effective for admissions on or after July 1, 1994, the payment is reduced further by multiplying it by 97 percent. The resulting payment is directly related to the hospital's volume of services provided to low-income MI patients. This payment reduction adjustment is applied to the MIDSH methodology established and in effect as of September 30, 1991 in accordance with Section 3(b) of the "Medicaid Voluntary Contributions and Provider-Specific Tax Amendment of 1991." The emergency medical expense requirement (EMER) deductible is not part of the MIDSH actual payment and will be deducted pre or post pay from the department's MI allowed amount (basic payment) to the hospital.

3. General Assistance Unemployable Disproportionate Share Hospital (GAUDSH) Payment

Effective July 1, 1994, hospitals shall be deemed eligible for a GAUDSH payment if:

- a. The hospital is an in-state or border area hospital; and,
- b. The hospital provides services to low-income, General Assistance Unemployable (GAU) patients. GAU persons are low-income individuals who are not eligible for any health coverage and who are encountering a medical condition; and,

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G. DSH PAYMENTS (cont.)

3. GAUDSH Payments (cont.)

- c. The hospital has a low-income utilization rate of one percent or more; and,
- d. The hospital qualifies under Section 1923 (d) of the Social Security Act.

Hospitals qualifying for GAUDSH payments will receive a periodic per claim payment. For all hospitals, except public hospitals located in the State of Washington that are owned by public hospital districts and are not department approved and DOH certified as CAH, the Harborview Medical Center, and the University of Washington Medical Center, the payment is determined for each hospital by reducing the regular Medicaid payment by a ratable reduction factor and equivalency factor adjustment. The ratable reduction is inversely proportional to the percent of a hospital's gross revenue for Medicare, Medicaid, Labor and Industries, and charity. The equivalency factor reduction is a budget neutral adjustment applied to all hospitals. For the excepted hospitals, the payment equals "full cost" using the Medicaid RCC to determine cost for the medically necessary care. The equivalency factor insures that GAUDSH payments will equal the State's estimated GAUDSH appropriation level.

4. Small Rural Hospital Assistance Program Disproportionate Share Hospital (SRHAPDSH) Payment

Effective July 1, 1994, hospitals shall be deemed eligible for a SRHAPDSH payment if:

- a. The hospital is an in-state (Washington) hospital; and
- b. The hospital provides at least one percent of its services to low-income patients in rural areas of the state; and
- c. The hospital is a small, rural hospital, defined as a hospital with fewer than 75 acute licensed beds and located in a city or town with a non-student population of 15,500 or less for state fiscal year (SFY) 2003 with this population standard to be increased by two percent each subsequent SFY; and
- d. The hospital qualifies under Section 1923(d) of the Social Security Act.